

# The governance of disease outbreaks in international health law

## From Ebola to COVID-19 (Part I)

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A deadly virus starts spreading in several communities. Reports are issued warning of the potential fallout if no action is taken. Yet both national authorities, as well as the WHO, the United Nations as such, and the international community as a whole are subjected to harsh criticism for ignoring the initial warning signs. Had they acted sooner, some say, more lives could have been saved. An overreliance on epidemiological assessments by national health authorities underplaying the dimensions of the outbreak leads to flawed decision-making by international institutions. As a result, the virus can spread across borders before sufficient awareness is raised. After a few months, the extent of the outbreak overwhelms national authorities in several countries. The need for a quick response is such that declarations of states of emergency follow suit. They include, among other things, exceptional executive powers as well as the derogation of human rights. The ensuing economic consequences for affected countries are devastating.

The above description may sound familiar. Yet, it does not refer to the COVID-19 pandemic we now witness. It is actually the setting of the beginning of the 2014-2016 West African Ebola Outbreak, a cross-border debacle mostly (though not exclusively) affecting Guinea, Liberia and Sierra Leone. While this event did not evolve into a full-blown pandemic, certain parallels to the present situation are easy to spot. Against this backdrop, a symposium was [hosted here at Völkerrechtsblog](#) in 2016, focusing on the Ebola crisis in West Africa. We then published an [edited volume on international health law in 2017](#) using this setting as a case study. Amidst the COVID-19 pandemic, it is high time for a look back at some of our claims.

While infectious disease outbreaks are complex, and thus comparable only to a certain extent, we show that international governance of such outbreaks builds upon common elements. These are the building blocks of international health governance; we wish to further explore here. Here we provide an overview of some of the findings of our edited volume and seek to apply them to the COVID-19 crisis. A blog entry can only open the discussion around these complex issues. Our portrayal of international law back then did not attest to today's shifting political settings, such as more recent setbacks of the multilateral world order, or the geopolitical wrestling between the US and China.

### Sketching the building blocks of international health governance

We argue that [there are building blocks of international health governance](#), which we can distinguish and that call for further research across individual disease outbreaks. From an international law perspective, these include 1) the institutional law governing the WHO; 2) the wider field of general international law, also allowing for contestation of the WHO in the securitization of health; and 3) the right to health of individuals. In the edited volume of 2017, we also showed how international law related to disease outbreaks inevitably requires a cross-cutting approach. International health governance is a developed field of research in public health, but not law. Besides legal scholarship, insights are needed from medical and public health specialists, political scientists, and anthropologists.

### **Does the type of disease matter for legal analysis, and how?**

Comparing disease outbreaks should be undertaken with methodological caution. The fact that the Ebola virus is quite different from the SARS-CoV-2 virus, which causes COVID-19, is in many ways relevant to the respective analysis. To begin with, they are epidemiologically distinct: The way of transmission and, therefore, degree of contagiousness is much higher for SARS-CoV-2. This may also explain why Ebola has fortunately not attained global transmission, although [there is an ongoing outbreak in the Democratic Republic of the Congo](#).

Moreover, countries with poor healthcare capacities were evidently more affected by Ebola in 2014-2016. The fact that the three countries most affected [ranked lowest](#) amongst multiple indices of preparedness and response in 2014 was seen as a catalyst. By contrast, no healthcare system has escaped the spread of COVID-19, though certainly some have fared much better than others.

Determining the factors underlying better vs. worse responses will be a monumental yet essential interdisciplinary task, not the least for legal scholars: Which public health measures, including the ones restricting liberties the most, were seen as key for an effective response? Can we really think of context-independent 'best practices' in pandemic response? If so, was there any correlation between 'success' or 'failure' and the underlying legal framework? What role, if any, did both constitutional and international law play in determining whether certain measures were adopted sooner rather than later?

We believe that the answers to these questions regarding the COVID-19 pandemic must inevitably draw upon the experiences of previous outbreaks. This is where we see a red thread along the building blocks that underlie the international governance of infectious disease. Yet, in the application of the norms to a concrete scenario, the type of disease matters. Gauging the legal adequacy of measures depends on empirical information related to risk determination. Our methodological approach – connected especially to the broader [international public authority \(IPA\)](#) framework – shows that international health governance is directly linked to the authority of international institutions such as the WHO or the [regional West African Organization](#). There is little case law where the normative argument and the empirical facts directly intersect. Thus, what is left is administrative decision-making by those international institutions.

## **The International Health Regulations' (IHR) trigger for COVID-19: The WHO's position**

The IHR is a legal instrument binding for all 194 WHO Member States, plus Liechtenstein and the Holy See. It provides the main legal framework for the international response against the cross-border spread of disease. Article 12 of the IHR authorizes the WHO's Director-General to declare an event a public health emergency of international concern. Though not creating new obligations for states, it represents an instance of executive decision-making raising alertness on the risk of international spread of a disease, as well as the need of an international response for its containment.

In 2014, the WHO [had a months-long delayed response](#) in raising the alert on the severity of the spread of Ebola in Guinea. The explaining factors are grounded on both internal and external governance elements. In the internal dimension, the institutional delay was inter alia due to a more diplomatic approach by then-WHO Director-General Margaret Chan. It seems [she was reluctant to confront the involved states](#), as national political leaders had an interest in not raising any alert and instead showing they had the outbreak under control. Also, she was to an extent burnt by the allegation to have triggered the WHO mandate too early during the 2009 H1N1 influenza pandemic. There is an inherent tension in prevention: If it works perfectly, the avoided harm will not materialize – the same as when the harm is over-dramatized. A broader, external governance dimension has to do with the consistent failure by states to develop [“core capacities”](#), as required under Article 5 of the IHR. Broadly speaking, states are required under Annex 1 IHR to enhance their systems to a point in which disease surveillance and reporting allows for prompt notification to the WHO. The yardsticks to measure the fulfillment of such capacities are quite variable. To this date, effective implementation of the IHR's obligations is mostly dependent on extent to which countries have functioning public health institutions and implementation capacities.

Six years after the outset of the West African Ebola crisis, what picture do we see? The WHO's responsiveness arguably improved, as seen in the constant engagement with the situation in China since the virus was officially reported (31 December 2019). [It is certainly not satisfactory to all](#) and is notably the subject of political scapegoating. Yet other persistent issues are still at hand. As addressed [elsewhere](#), the vagueness in some of the applicable legal norms, particularly those of the IHR, leads to diverging interpretations of states' obligations. Their function is to foster coordinated responses to the cross-border spread of diseases. The WHO may then recommend the adoption of specific public health measures in response to an outbreak.

In its time, the IHR 2005 revision was greeted as an improvement. The IHR are no longer limited to certain diseases, and expert panels are involved for evidence-based policy recommendations. But the WHO's own interpretation of its mandate and powers is rather inconsistent, for instance when there is unclarity or hesitation in labelling an event a public health emergency of international concern under Article 12. The value of technical recommendations by the WHO (Article 15 IHR), which back in 2014 as well as in January 2020 included not adopting travel bans to virus-

affected countries, is still the subject of debate. The lack of oversight of states' obligations to notify the WHO on several fronts is blatant. In sum, the WHO is still too prone to policy, and not normativity. A legal perspective focused on consistent interpretation criteria, as well as clearer reasoning justifying specific decisions, could sharpen this building block of international health governance.

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